House Bill 5:
Temporary Funding Extension for Group Homes & Special Care Units.

BILL ANALYSIS

Committee:	Senate Appropriations	**Introduced by:**	
Date:	February 20, 2013	**Summary by:**	Joyce W. Jones, Staff Attorney
Version:	PCS H5-CSMG-4 (v. 9)		

SUMMARY: The Proposed Committee Substitute for House Bill 5 directs the Department of Health and Human Services (DHHS) to provide temporary, short-term financial assistance: (1) to group homes in the form of monthly payments to support the continued provision of services to group home residents who became ineligible for Medicaid covered Personal Care Services (PCS) as a result of Medicaid State Plan changes in PCS eligibility criteria that became effective on January 1, 2013, and (2) to special care units in the form of supplemental monthly payments to support the continued provision of special care services to residents who qualify for PCS, but for a reduced number of hours per month, as a result of the changes to PCS eligibility criteria that went into effect on January 1, 2013. The bill requires that both the monthly payments to group homes and the supplemental monthly payments to special care units be made from $39.7 million dollars of existing, budgeted non-recurring Transitions to Community Living funds designated for similar short-term financial assistance to adult care homes. The Proposed Committee Substitute also removes as a criterion for adult care homes to receive these funds on behalf of any resident, the completion of an independent assessment process for the resident prior to December 31, 2012.

Section 1.(a) – Defines "group home" as any facility that (i) is licensed under Chapter 122C of the General Statutes, (ii) meets the definition of a supervised living facility under 10A NCAC 27G .5601, and (iii) serves adults whose primary diagnosis is mental illness or a developmental disability but may also have other diagnoses. 10A NCAC 27G .5601 defines a supervised living facility as "a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities … and who require supervision when in the residence."

Section 1.(b) – Directs DHHS to provide temporary, short-term monthly payments to group homes on behalf of residents who were eligible for Medicaid covered PCS prior to January 1, 2013, but lost that eligibility due to Medicaid State Plan changes in PCS eligibility criteria specified in the current budget bill, which became effective on January 1, 2013.

DHHS must make the monthly payments to group homes from $39.7 million dollars of existing, budgeted nonrecurring Transitions to Community Living funds appropriated for the 2012-2013 fiscal year to provide similar short-term financial assistance to adult care homes whose residents no longer qualify for PCS based on the eligibility changes that went into effect on January 1, 2013.

The monthly payments to group homes are subject to the following five requirements and limitations:

1. Monthly payments cannot exceed $694.00 per resident per month for a maximum of 3 months; after three months, payments must be reduced by 25% and cannot exceed $525.50 per resident per month.
2. Monthly payments can only be made for the period commencing February 1, 2013, and ending June 30, 2013.

3. Monthly payments can only be made for as long as sufficient funds are available from the $39.7 million dollars of existing, budgeted nonrecurring funds appropriated for the 2012-2013 fiscal year.
4. DHHS cannot make monthly payments to a group home on behalf of any resident who has an appeal pending under G.S. 108A-70.9A. [In accordance with federal regulations, maintenance of (personal care) services – "MOS" – will be available for group home residents whose proper request for continuation of PCS has been denied and who have filed a timely appeal.]
5. All monthly payments to group homes terminate on June 30, 2013, or upon depletion of the $39.7 million dollar appropriation, whichever is sooner.

Section 1.(c) – Directs DHHS to provide temporary, short-term supplemental monthly payments to licensed special care units on behalf of residents who were eligible for PCS prior to January 1, 2013, and are determined eligible for PCS on or after January 1, 2013, based on new eligibility criteria specified in the current budget bill, which became effective on January 1, 2013.

DHHS must make the monthly supplemental payments to special care units from $39.7 million dollars of existing, budgeted nonrecurring Transitions to Community Living funds appropriated for the 2012-2013 fiscal year to provide similar short-term financial assistance to adult care homes (and now group homes per Section 1.(b)) whose residents no longer qualify for PCS based on the eligibility changes that went into effect on January 1, 2013.

The monthly supplemental payments to special care units are subject to the following six requirements and limitations:

1. Supplemental monthly payments cannot exceed $268.00 per resident per month.
2. Special care units can only use the supplemental monthly payments for the continued provision of special care services for which the resident does not otherwise receive Medicaid coverage. [Federal and State regulations require Medicaid providers to accept the amounts paid by DHHS plus any authorized deductible, coinsurance, or copayment as payment in full for all Medicaid covered services.]
3. Supplemental monthly payments can only be made for the period commencing March 1, 2013, and ending June 30, 2013.
4. Supplemental monthly payments can only be made for as long as sufficient funds are available from the $39.7 million dollars of existing, budgeted nonrecurring funds appropriated for the 2012-2013 fiscal year.
5. DHHS cannot make supplemental monthly payments to a special care unit on behalf of any resident who has an appeal pending under G.S. 108A-70.9A. [In accordance with federal regulations, maintenance of (personal care) services – "MOS" – will be available for special care unit residents whose proper request for continuation of PCS at the prior level has been denied and who have filed a timely appeal.]
6. All supplemental monthly payments to special care units terminate on June 30, 2013, or upon depletion of the $39.7 million dollar appropriation, whichever is sooner.

Section 1.(d) – Voids the requirement in the current budget bill that an adult care home resident must complete an independent assessment process by December 31, 2012, in order for the adult care home to receive temporary, short-term supplemental monthly payments on behalf of the resident. Adult care homes are still required to meet all other requirements for receiving these monthly payments that are imposed on them in the current budget bill.

Section 2. – Expressly states that DHHS will not be required to provide any temporary, short-term financial assistance to adult care homes, group homes, or special care units beyond the end of the current fiscal year, or upon depletion of the $39.7 million dollar appropriation, whichever is sooner.

Section 3. – In order to ensure compliance with federal Medicaid comparability requirements and the settlement agreement between the United States Department of Justice and the State of North Carolina, directs the General Assembly not to appropriate any additional State funds for the current fiscal biennium for the purpose of providing temporary, short-term financial assistance to adult care homes, group homes, or special care units on behalf of residents impacted by the changes to PCS that went into effect on January 1, 2013.

Section 4. – Effective Date: Section 1 is effective when the act becomes law and expires on June 30, 2013. Sections 2, 3, and 4 are effective when the act becomes law.

BACKGROUND: The new PCS eligibility criteria specified in Section 10.9F(c) of S.L. 2012-142, as amended by Section 70 of S.L. 2012-194, raised the level of disability a resident of a licensed care home setting such as a group home, special care unit, or adult care home must demonstrate in order to qualify for the benefit, and also reduced the maximum number of hours of Medicaid covered PCS a recipient could receive each month from 120 hours to 80 hours. A resident in a licensed care home setting such as a group home, a special care unit, or an adult care home can now qualify for a maximum of 80 hours of PCS per month if the resident has a medical condition, disability, or cognitive impairment and demonstrates unmet needs for, at a minimum, (i) three of the five qualifying activities of daily living (ADLs) with limited hands-on assistance; (ii) two ADLs, one of which requires extensive assistance; or (iii) two ADLs, one of which requires assistance at the full dependence level. The five qualifying ADLs are eating, dressing, bathing, toileting, and mobility.

The exact number of hours of PCS for each qualifying resident is determined in accordance with (i) an independent assessment of the resident's degree of functional disability and level of unmet needs for PCS in the five qualifying ADLs and (ii) a plan of care developed by the licensed home and approved by DHHS, Division of Medical Assistance, or its designee. PCS covers hands-on assistance with ADLs, including bathing, dressing, mobility, toileting, and eating. PCS may also include assistance with related home management tasks, medications, adaptive or assistive devices, and durable medical equipment if the assistance is directly related to the resident's qualifying ADLs. PCS does not cover transportation; financial management; non-hands-on assistance such as cueing, prompting, guiding, coaching, or babysitting; or household chores not directly related to the resident's qualifying ADLs.

The recent changes to eligibility criteria for receiving PCS were prompted by notification from the federal Centers for Medicare and Medicaid Services (CMS) that North Carolina's PCS benefit was not in compliance with Medicaid comparability requirements. Under those requirements, the State Medicaid Plan must provide that the services available to any categorically needy recipient under the Plan are not less in amount, duration, and scope than those services available to a medically needy recipient, and the Plan must provide that the services available to any individual in the categorically needy or medically needy group are equal in amount, duration, and scope for all recipients within the group. Prior to January 1, 2013, the eligibility criteria for receiving PCS in an institutional setting were less stringent than

the criteria for receiving PCS in a residential setting. CMS has determined that the enacted changes to the PCS benefit that went into effect on January 1, 2013, achieve federal Medicaid comparability requirements by making PCS eligibility criteria the same in all settings.

The purpose of the settlement agreement dated August 23, 2012, between the United States Department of Justice (USDOJ) and the State of North Carolina is to assure that persons with mental illness are allowed to reside in their communities in the least restrictive settings of their choice. The settlement agreement is the end product of over a year of negotiations between the State and the USDOJ. The Department began implementing the agreement through the Transitions to Community Living Initiative described in Section 10.23A of the current budget bill, which provides the source of Transitions to Community Living funds for the temporary, short-term financial assistance authorized for adult care homes, group homes, and special care units under this act and the current budget bill.